



INDIANA FIRST STEPS EARLY INTERVENTION SYSTEM EXIT SUMMARY

State Form 51310 (R / 3-05) / BCD 0087



| | |
|--|--|
| Child and family First Steps ID Number | |
| Child date of birth (<i>month, day, year</i>) | |
| County of residence | |
| Name of Service Coordinator | Telephone number () |
| Date (<i>month, day, year</i>) | |
| <p>This survey is used to find out how First Steps services have helped children and families. It is a checklist to record what the child and family knows and can do as a result of First Steps. It is an assessment of how effective First Steps has been, NOT an assessment of child or family progress!</p> <p>The Service Coordinator will work with the family and service providers who are on that family's team to complete this survey. The Service Coordinator will work with all service providers on the team to complete Section 1: Child Learning and Development. The Service Coordinator will meet with the family to complete Section 2: The Family; and Section 3: Child, Home, and Community.</p> <p>This survey must be completed just before the family's transition from the First Steps Early Intervention System. It is strongly recommended that it be completed during the last face-to-face meeting the Service Coordinator has with the family. This survey can and should be used as part of an "exit interview" with the family. It can be used to review the progress that has been made during the child and family's time in First Steps.</p> <p><u>This information is confidential.</u> It will not be shared with any other program. It will only be used to help the First Steps Early Intervention System do a better job for future children and families.</p> | |
| Have you moved since you started in First Steps? <input type="checkbox"/> Yes <input type="checkbox"/> No | If Yes, what was the original First Steps ID number? |
| If there is a medical diagnosis, please list here: <hr style="border-top: 1px dashed black;"/> | |
| Signature of parent or caregiver | Date (<i>month, day, year</i>) |

SERVICE COORDINATOR ONLY

Unable to complete Exit Summary (*please document attempts to schedule exit meeting with family*)

INDIANA FIRST STEPS EARLY INTERVENTION SYSTEM EXIT SUMMARY

State Form 51310 (R / 3-05) / BCD 0087



| | |
|---------------|------|
| Name of child | ID # |
|---------------|------|

SECTION 1: CHILD DEVELOPMENT

An important outcome of First Steps is for **children to learn important and essential developmental skills**. The questions in this section provide a summary of the child's development and learning. Professionals who assessed the child and have accurate information about the child's development should complete this section. Please respond to all questions as accurately as possible.

1. What is the child's current level of development? Please fill in the blank indicating the child's developmental age in months for each area. If the child is delayed in an area, please check if specialized services after First Steps are still needed and recommended.

| DOMAIN | STATEMENT OF CHILD'S CURRENT LEVEL OF PERFORMANCE <i>Please provide age scores. Check if services are recommended.</i> | | |
|-----------------------------|---|-----------|---------------|
| COGNITION | Developmental age | OR | Percent delay |
| | Services recommended: <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| PHYSICAL DEVELOPMENT | Developmental age | OR | Percent delay |
| | Services recommended: <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| COMMUNICATION | Developmental age | OR | Percent delay |
| | Services recommended: <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| SOCIAL / EMOTIONAL | Developmental age | OR | Percent delay |
| | Services recommended: <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| ADAPTIVE | Developmental age | OR | Percent delay |
| | Services recommended: <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

INDIANA FIRST STEPS EARLY INTERVENTION SYSTEM EXIT SUMMARY

State Form 51310 (R / 3-05) / BCD 0087



| | |
|---------------|------|
| Name of child | ID # |
|---------------|------|

SECTION 1: CHILD DEVELOPMENT (*continued*)

2. What important developmental skills is the child currently performing? This is a list of functional developmental milestones. Please indicate if the child is able to perform each of the following skills. Please check “Yes” if he or she can perform the skill without help, “With Help” if he or she needs assistance, or “No” if your child cannot perform the skill.

| GROSS MOTOR SKILLS: to sit up, move around, and play physical games. | NO | WITH HELP | YES |
|---|--------------------------|--------------------------|--------------------------|
| Holds head steady | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Rolls over | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sits | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Crawls on hands and knees | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Pulls to standing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Walks | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Goes up and down stairs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Walks while carrying toys | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| SOCIAL-EMOTIONAL SKILLS: to develop positive social relationships | NO | WITH HELP | YES |
|--|--------------------------|--------------------------|--------------------------|
| Responds to adult interaction | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Tries to attract adult attention with movement or vocalizations | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Plays by self with toys for a short time (10-15 min) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Initiates and maintains positive social games with peers and adults | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Shares with peers | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Solves problems in interactions with others | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| FINE MOTOR SKILLS: to use arms and hands to reach, grasp and play with objects and toys | NO | WITH HELP | YES |
|--|--------------------------|--------------------------|--------------------------|
| Reaches toward person or object | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Grasps large objects | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Grasps small objects | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Marks on paper with crayon, marker, etc. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Unfastens clothing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Plays with toys/objects in a coordinated manner | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| COGNITIVE & LEARNING SKILLS: to gain knowledge and solve problems | NO | WITH HELP | YES |
|--|--------------------------|--------------------------|--------------------------|
| Responds to sensory stimuli (<i>noise, light, touch</i>) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Imitates pat-a-cake or other familiar games | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Looks for toys in familiar places | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Plays simple imaginary games | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Can tell what happened or what was said earlier | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Recognizes name in print | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| COMMUNICATION SKILLS: to understand others, to express their own thoughts | NO | WITH HELP | YES |
|--|--------------------------|--------------------------|--------------------------|
| Looks toward face or sound | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Smiles | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Babbles (<i>uses no words yet</i>) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Uses gestures to communicate | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Understands “no” + name | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Uses words to make requests | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Understands simple directions | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Uses simple sentences | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Starts or continues conversations | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| ADAPTIVE SKILLS: to feed, bathe, dress, and toilet him or herself | NO | WITH HELP | YES |
|--|--------------------------|--------------------------|--------------------------|
| Eats from a bottle or breast | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cooperates in washing at bath time | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cooperates in dressing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Removes clothing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Uses utensils to feed self | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Indicates need for toileting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

INDIANA FIRST STEPS EARLY INTERVENTION SYSTEM EXIT SUMMARY

State Form 51310 (R / 3-05) / BCD 0087



| | |
|---------------|------|
| Name of child | ID # |
|---------------|------|

SECTION 2: THE FAMILY

A number of important outcomes focus on the child's family. They include helping the family to:

- **work with the First Steps team to support their child's development;**
- **know their rights and be strong advocates for their child and family;**
- **keep their child and other family members safe and healthy; and**
- **connect to other families and community associations in times of emotional need.**

The questions in this section provide a summary of the information and skills the family may have gained during the time their child was in First Steps.

| 3. Enhancing my child's learning and development. As I leave First Steps ... | YES, MOST OF THE TIME | SOME OF THE TIME | NO, NOT OFTEN |
|--|--------------------------|--------------------------|--------------------------|
| 3.1. I am comfortable knowing how to support my child's learning and development in the areas of: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| a. COMMUNICATION skills - to understand others, to express his or her own thoughts, and to carry on simple conversations | | | |
| b. COGNITIVE skills - to gain new knowledge, to solve problems | | | |
| c. GROSS MOTOR skills - to sit up, move around, and to play physical games | | | |
| d. FINE MOTOR skills - to reach, grasp or hold, and play with toys and objects | | | |
| e. SOCIAL/EMOTIONAL skills - to develop positive social relationships | | | |
| f. ADAPTIVE skills - to feed, dress, bathe, and toilet him or herself | | | |
| 3.2. I understand my child's special needs and how they affect his or her development. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3.3. I know what toys and books are good for my child at his/her age. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3.4. I know how to handle temper tantrums or other behaviors that upset me. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3.5. I know how to toilet train my child. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3.6. I know how to play and talk with my child. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3.7. I know how to help my child develop good sleeping habits. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3.8. I know how to provide opportunities for my child to play with other children. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Supporting my child's health, safety, and nutrition. As I leave First Steps ... | | YES | NO |
| 4.1. My child sees a doctor regularly for checkups or when he or she is sick. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.2. I know when my child needs his or her immunizations (<i>shots</i>). | | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.3. My child is all caught up on his or her immunizations (<i>shots</i>). | | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.4. My family has adequate health insurance coverage. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.5. I know what to feed my child so that he or she has well-balanced meals. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.6. My child eats well and has a balanced diet. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.7. I know how to find information about these common household safety measures: | | <input type="checkbox"/> | <input type="checkbox"/> |
| a. safe sleep (<i>reducing the risk of Sudden Infant Death Syndrome</i>) | | <input type="checkbox"/> | <input type="checkbox"/> |
| b. using a car seat in the back seat of our car | | <input type="checkbox"/> | <input type="checkbox"/> |
| c. the possible health and developmental risks of second-hand smoke for infants and young children | | <input type="checkbox"/> | <input type="checkbox"/> |
| d. having plastic outlet plugs in all electrical outlets | | <input type="checkbox"/> | <input type="checkbox"/> |
| e. having working smoke detectors | | <input type="checkbox"/> | <input type="checkbox"/> |
| f. having our medicines and poisons out of reach of our child/children | | <input type="checkbox"/> | <input type="checkbox"/> |
| g. keeping guns in places our child/children cannot reach | | <input type="checkbox"/> | <input type="checkbox"/> |
| h. having our home checked for lead paint | | <input type="checkbox"/> | <input type="checkbox"/> |

INDIANA FIRST STEPS EARLY INTERVENTION SYSTEM EXIT SUMMARY

State Form 51310 (R / 3-05) / BCD 0087



| | |
|---------------|------|
| Name of child | ID # |
|---------------|------|

| SECTION 2: THE FAMILY (continued) | | | |
|---|------------------------------|--------------------------|--------------------------|
| 5. Knowing what I can do as a member of the First Steps Team. As I leave First Steps ... | YES | NO | |
| 5.1. I know about and understand the purpose of the evaluation and ongoing assessment of my child and family. | <input type="checkbox"/> | <input type="checkbox"/> | |
| 5.2. I know that I can share information about my child and family as part of the assessment. | <input type="checkbox"/> | <input type="checkbox"/> | |
| 5.3. I did share information about my child and family as part of the last assessment. | <input type="checkbox"/> | <input type="checkbox"/> | |
| 5.4. I know about and understand the purpose of the Individualized Family Service Plan (IFSP) and the meetings to develop them. | <input type="checkbox"/> | <input type="checkbox"/> | |
| 5.5. I know that I can share what I think are important outcomes and services for the IFSP. | <input type="checkbox"/> | <input type="checkbox"/> | |
| 5.6. I know that I can agree or disagree with the recommendations made by other members of the team. | <input type="checkbox"/> | <input type="checkbox"/> | |
| 5.7. At the last IFSP meeting, I shared my outcomes for what I wanted to happen. | <input type="checkbox"/> | <input type="checkbox"/> | |
| 5.8. At the last IFSP meeting, I expressed my agreement with the recommendations made by the team. | <input type="checkbox"/> | <input type="checkbox"/> | |
| 5.9. At the last IFSP meeting, I expressed my disagreement with the recommendations made by the team. | <input type="checkbox"/> | <input type="checkbox"/> | |
| 5.10. I know that there are things I can do at home to carry out the recommendations made by other members of the team. | <input type="checkbox"/> | <input type="checkbox"/> | |
| 5.11. I am doing things at home that are a part of the IFSP and the team's recommendations. | <input type="checkbox"/> | <input type="checkbox"/> | |
| 6. Knowing my rights and how to be a strong advocate for my child and family. As I leave First Steps ... | YES | NO | |
| 6.1. I know about and understand my rights under First Steps. | <input type="checkbox"/> | <input type="checkbox"/> | |
| 6.2. I know I can advocate for my child and family in a number of ways, including: | | | |
| a. sharing my concerns, needs, and priorities | <input type="checkbox"/> | <input type="checkbox"/> | |
| b. choosing the services and providers I feel we need | <input type="checkbox"/> | <input type="checkbox"/> | |
| c. adding, changing, or stopping services or providers | <input type="checkbox"/> | <input type="checkbox"/> | |
| d. refusing permission for services or activities | <input type="checkbox"/> | <input type="checkbox"/> | |
| 6.3. If I disagree with my service providers, I know how to work together with them to find a solution. | <input type="checkbox"/> | <input type="checkbox"/> | |
| 6.4. In the past 3 months, I have disagreed with at least one of my child and family's service providers. | <input type="checkbox"/> | <input type="checkbox"/> | |
| 6.5. If there was a disagreement, I felt that I was able to work together with my provider to solve the problem. | <input type="checkbox"/> | <input type="checkbox"/> | |
| 7. Connecting with other families, associations, and community organizations for information and support. As I leave First Steps ... | YES, MOST OF THE TIME | SOME OF THE TIME | NOT OFTEN |
| 7.1. I have information and resources to meet my family's: | | | |
| a. transportation needs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. housing needs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. job needs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. education needs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7.2. When I need information or emotional support, I know I can contact: | | | |
| a. friends or other family members | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. other families with children who have special needs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. family support groups and associations | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. formal community agencies | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7.3. In the past 3 months, I have connected with other families or community supports for information and emotional support. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**INDIANA FIRST STEPS EARLY INTERVENTION SYSTEM
EXIT SUMMARY**

State Form 51310 (R / 3-05) / BCD 0087



| | |
|---------------|------|
| Name of child | ID # |
|---------------|------|

SECTION 3: CHILD, HOME, AND COMMUNITY

A second important outcome of First Steps is for **children to participate and be fully included in everyday activities, settings, and routines in the home and community.** The questions in this section provide a summary of the child's participation in home and community settings.

| 8. My child is able to complete the following routines successfully: | NO, NOT AT ALL | YES, BUT WITH HELP | YES, WITHOUT HELP | |
|---|--------------------------|--------------------------|--------------------------|--|
| 8.1. Getting up in the morning | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 8.2. Dressing and undressing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 8.3. Meal times | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 8.4. Inside play times | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 8.5. Outside play times | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 8.6. Getting along with siblings and peers | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 8.7. Participating in family games and activities | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 8.8. Nap times | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 8.9. Toileting times | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 8.10. Getting ready to go/leave home | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 8.11. Going to bed in the evening | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 9. In the past 2 weeks, my child has gone with my family to the following community activities or settings: | WE DON'T GO THERE | NO | YES | CHECK IF THIS IS STILL DIFFICULT |
| 9.1. Grocery shopping | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9.2. Shopping, but not for groceries | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9.3. Visiting relatives, friends, or neighbors | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9.4. Going out to eat | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9.5. Attending church/temple/religious services | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9.6. Toddler play groups | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9.7. Family day care home | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9.8. Child care center | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9.9. Child care center for children with special needs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9.10. Head Start | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9.11. Community activities with other children (e.g., library, YMCA) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9.12. Mother's day out | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9.13. Go with family member to a community event | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9.14. Other (please list other community setting): | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. In the past month, I have had the following experiences with child care and other community programs: | NOT APPLICABLE | YES | NO | |
| 10.1. Child care program has welcomed and included my child | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 10.2. Child care program provides safe and healthy care | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 10.3. Child care program meets my child's individual needs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 10.4. Community activities and programs for young children (e.g., YMCA, library reading programs, swimming) have welcomed and included my child | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 10.5. Community activities and programs for young children have appropriately involved my child | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |

INDIANA FIRST STEPS EARLY INTERVENTION SYSTEM EXIT SUMMARY

State Form 51310 (R / 3-05) / BCD 0087



| | |
|---------------|------|
| Name of child | ID # |
|---------------|------|

SECTION 4: LEAVING FIRST STEPS

Another important outcome of First Steps is for **children and families to have successful transitions out of First Steps and into appropriate community programs and services**. The questions in this section provide a picture of how well the transition process happened for you and your family.

11. Why are your child and family transitioning out of First Steps? *(please check one)*

- | | |
|--|---|
| <input type="checkbox"/> Our child no longer needs First Steps services. | <input type="checkbox"/> Our child is three years old. |
| <input type="checkbox"/> We have decided to find services elsewhere. | <input type="checkbox"/> Our family is moving out of state. |

12. Have you had a planning meeting for your child's transition out of First Steps?

- Yes, 90 days or more before the third birthday *(or the date your child leaves First Steps)*.
- Yes, less than 90 days before the third birthday *(or the date your child leaves First Steps)*.
- No.

13. If your child is turning 3 years of age AND you answered "No" to question 12, why did this meeting NOT happen? *(skip this question if your child is not turning 3)*

- | | |
|--|--|
| <input type="checkbox"/> My child did not become involved in First Steps until after that date had passed. | <input type="checkbox"/> I did not know about it. |
| <input type="checkbox"/> I chose to wait until closer to my child's birthday. | <input type="checkbox"/> I chose not to have a transition meeting. |

14. As your child and family leave First Steps, what choices have you made for your child? *(check all that apply)*

| | YES | NO |
|--|-----|----|
|--|-----|----|

- | | | |
|--|--------------------------|--------------------------|
| 14.1. My child will continue to attend the community child care or preschool he/she has been attending up to this point. | <input type="checkbox"/> | <input type="checkbox"/> |
| 14.2. My child will get therapy from a hospital, clinic or private therapist. | <input type="checkbox"/> | <input type="checkbox"/> |
| 14.3. My child will attend a Head Start program. | <input type="checkbox"/> | <input type="checkbox"/> |
| 14.4. <i>(If you checked "Yes" to any of the choices above)</i> A representative from that program did attend our 90-day transition meeting. | <input type="checkbox"/> | <input type="checkbox"/> |
| 14.5. My child will be enrolled in the public school's Early Childhood Special Education program <i>(if turning 3 years old)</i> . | <input type="checkbox"/> | <input type="checkbox"/> |
| 14.6. My child will attend a community child care or preschool and receive therapy from the school system. | <input type="checkbox"/> | <input type="checkbox"/> |
| 14.7. My child will continue to stay at home with my family <i>(rather than attending child care)</i> . | <input type="checkbox"/> | <input type="checkbox"/> |
| 14.8. First Steps has provided the information I need to make these choices. | <input type="checkbox"/> | <input type="checkbox"/> |

If you checked "Yes" for numbers 14.5 or 14.6, please answer this last section.

15. If your child will be enrolled in the public school's Early Childhood Special Education program, did the following happen?

| | YES | NO |
|--|-----|----|
|--|-----|----|

- | | | |
|---|--------------------------|--------------------------|
| 15.1. The school district was notified about our child during his/her 18th month. | <input type="checkbox"/> | <input type="checkbox"/> |
| 15.2. The school district was given more information about our child during his/her 30th month. | <input type="checkbox"/> | <input type="checkbox"/> |
| 15.3. The school district was invited to our 90-day transition meeting. | <input type="checkbox"/> | <input type="checkbox"/> |
| 15.4. The school sent a representative to the 90-day transition meeting. | <input type="checkbox"/> | <input type="checkbox"/> |
| 15.5. An evaluation has been done or is scheduled. | <input type="checkbox"/> | <input type="checkbox"/> |
| 15.6. The IEP meeting has happened or is scheduled. | Date of evaluation: | <input type="checkbox"/> |
| | Date of meeting: | <input type="checkbox"/> |